CONTRACT #3
RFS # 317.04-003

Department of Finance & Administration/Insurance Administration

VENDOR:
Medstat Group

REQUEST: NON-COMPETITIVE AMENDMENT

RECEIVED

AUG 17 2005

FISCAL REVIEW

APPROVED

Commissioner of Finance & Administration
Date:

EACH REQUEST ITEM BELOW MUST BE DETAILED OR ADDRESSED AS REQUIRED.	
1) RFS #	317.04-003
2) State Agency Name :	F & A – Insurance Administration
EXISTING CONTRACT INFORMATON	
3) Service Caption :	Medical Claims Decision Support System (Data Storage Analysis)
4) Contractor :	The Medstat Group, Inc.
5) Contract #	FA 5114095
6) Contract Start Date : (attached explanation required if date is < 60 days after F&A receipt)	January 1, 1995
7) Current Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2005
8) Current Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$3,400,000
PROPOSED AMENDMENT INFORMATON	
9) Proposed Amendment #	6
10) Proposed Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2008
11) Proposed Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$5,000,000
12) Approval Criteria : (select one)	☒ use of Non-Competitive Negotiation is in the best interest of the state
	☐ only one uniquely qualified service provider able to provide the service
13) Description of the Proposed Amendment Effects & Any Additional Service :	
See letter from Richard Chapman to Dave Goetz dated August 16, 2005	
14) Explanation of Need for the Proposed Amendment :	
See attached.	
15) Name & Address of Contractor's Current Principal Owner(s) : (not required if proposed contractor is a state education institution)	

The Medstat Group, Inc., 777 East Eisenhower Parkway, Ann Arbor, MI 48108

16) Documentation of Office for Information Resources Endorsement :
(required only if the subject service involves information technology)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

17) Documentation of Department of Personnel Endorsement :
(required only if the subject service involves training for state employees)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

18) Documentation of State Architect Endorsement :
(required only if the subject service involves construction or real property related services)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

19) Description of Procuring Agency Efforts to Identify Reasonable, Competitive, Procurement Alternatives :

See attached correspondence.

20) Justification for the Proposed Non-Competitive Amendment :

See attached correspondence.

REQUESTING AGENCY HEAD SIGNATURE & DATE :
(must be signed & dated by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR— signature by an authorized signatory will be accepted only in documented exigent circumstances)

Agency Head Signature **Date**

RULE EXCEPTION REQUEST

APPROVED
Commissioner of Finance & Administration Date:

RFS #	317.04-003	STATE AGENCY:	F & A - Insurance Administration

INFORMATION ABOUT THE EXCEPTION(S) REQUESTED

SUBJECT RULE NUMBER(S) : 0620-3-3-.07 General Requirements, Paragraph (5) Contract Term

DESCRIPTION OF EXCEPTION(S) :

This exception will extend the contract term beyond the allowed 60 months.

JUSTIFICATION FOR EXCEPTIONS :
(compelling reasons for contracts rule exception; relevant background information; attach additional justification as necessary)

See attached letter from Richard Chapman to Dave Goetz dated August 16, 2005.

INFORMATION REGARDING THE APPLICABLE CONTRACT

DESCRIPTION OF SERVICE TO BE PROCURED :

Medical Claims Decision Support System (Data Storage Analysis)

BEGIN DATE:	January 1, 1995	END DATE (including ALL options for term extension):	December 31, 2005

MAXIMUM LIABILITY (including ALL options for term extension): $3,400,000

AGENCY HEAD REQUEST SIGNATURE:
(signed by the procuring agency head or authorized signatory)

M. D. Goetz, Jr.

SIGNATURE DATE: 8-17-05

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
INSURANCE ADMINISTRATION
312 Eighth Avenue North
Suite 1300 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-3590 or (800) 253-9981
FAX (615) 741-8196

Dave Goetz
COMMISSIONER

Richard Chapman
DIRECTOR

August 16, 2004

Dave Goetz, Commissioner
Department of Finance and Administration
First Floor, State Capital
Nashville, TN 37243

Dear Commissioner Goetz:

This request is submitted in support of the attached *Request for Approval: Non-competitive Contract Amendment (#FA-99-5114095-06)*. As required by the *Request for Approval* format, this letter contains the following:

1) A description of the proposed additional service and amendment effects;

The State of Tennessee sponsors health insurance for employees and retirees of state government and higher education, as well as local school systems and local government agencies. Specifically, the state offers three, optional insurance plans: A preferred Provider Plan (PPO), a Point of Service Plan (POS) and a Health Maintenance Organization (HMO). At the end of 2004, over 134,000 employees and retirees in addition to over 125,000 of their eligible dependents participated in these plans. These 259,000 lives accounted for over $850 million in claims during 2004.

Each of the health insurance plan options are self insured, therefore the risk is assumed by the participating entities. Four separate and distinct funds constitute the financial "risk pools" established for the administration of the financial activity of the Plans.

In order to effectively manage the risk for each of the plans; timely, reliable and accurate claims information must be available through a claims analysis system that provides the necessary detail to support analytical activity and complex decision-making. In order to meet this need, the Insurance Committees have contracted through a competitive procurement process with The Medstat Group for a claims analysis decision support system. The main decision support product tool of the Medstat system is "Decision Analyst" which provides Internet access through standard and custom designed programs to 36 months of health claims data for all of the state health plan options. An additional tool "Net Effect" is a program providing Internet access to standard executive reports on plan cost and use. Together, Decision Analyst and Net Effect comprise the Medstat "Advantage Suite" system. Access to this claims information provides the state with enhanced tool for the planning, management and administrative support for all plans.

The amendment calls for a three-year extension to the existing contract, allowing for the continued provision of these services for an additional three year period. The present contract termination date is

December 31, 2005. The amendment would extend the contract to December 31, 2008 and would not significantly change the scope of services.

The authorization to pursue a three year extension to the Medstat contract received approval by the Insurance Committees at their meeting of May 13, 2005.

2) Explanation of need for the proposed amendment:

The ability to understand the many factors that are influencing the trends in claims experience for each of the options is essential to the effective administration and management of these plans. This understanding cannot occur without the consistent and timely access to the detailed claims data provided through a decision support system. The system provides the ability to secure, through on line Internet access, claims information specific to each plan. Subsetting capabilities allow detailed analysis at the claim, member, clinical and provider level. Specific examples of activities and benefits that are supported through the Medstat system are as follows:

- Data and statistics showing various cost and utilization data by plan and healthcare option are derived on an ongoing basis. This data is used to prepare an array of charts, tables, and graphs for use on the Division of Insurance Administration's website and to provide information to members of the Insurance Committees to make informed decisions about the health plans.
- Through detailed analysis of the utilization and cost of medical and pharmacy services, identification of those factors that are contributing to rising health care costs can take place. The trends within groups with differing demographic characteristics including age and sex of plan members can be analyzed and used in planning modifications in plan benefits.
- Through modeling, the impact of specific benefit changes on future claims cost to the Plan and to its members can be estimated.
- Analysis of contractual risk sharing agreements can determine and validate the liability for the claims administrator and the state.
- Analysis of specific past claims trends enhance the validity of projection methods for determining funding needs.
- Analysis of the cost and prevalence of chronic conditions among plan members guides the development and evaluation of care and disease management programs.
- Determination of incurred but unreported claims is used to establish future reserve funding needs and in the preparation of each of the year-end audited financials.
- The Division of State Audit utilizes claims data to determine the focus of plan audits.
- Claims data provides needed plan historical claims experience needed to enhance information for competitive proposals.
- The fiscal impact of proposed legislation on state-sponsored plans can be estimated through the analysis of cost and use data.

Changing to a different claims analysis decision support system, other than the present Medstat system, would adversely impact the consistency and availability of the three years of detailed claims data necessary to effectively administer and management the state sponsored self insured health plans. Claims data is submitted quarterly to Medstat from contracted claims administrators (Blue Cross, John Deere, Aetna and Magellan Health Services) under the format required. If needed the state has access to claims information in the Medstat data warehouse from 1995 forward. Changing to a new claims analysis and decision support system would require additional time and cost for the state and claims administrators to change required data transmittal format.

In addition, a new system would require training of staff in the new system. These factors would cause a loss of access to the decision support system for an extended period with even the possible loss of historical claims data.

It would not be beneficial to the state at this time to seek a competitive procurement for the existing Medstat decision support system. The loss of this tool could negatively affect the ability to continue to effectively manage the state sponsored self-insured plans. The three-year extension to the existing contract from January 1, 2006 through December 31, 2008 with the Medstat Group would provide continuity to the state for the continued provision of these necessary services.

In addition to the reasons mentioned above, The Governmental Accounting Standards Board (GASB) will require, effective January 1, 2007, that state and local governmental employers provide an accounting and reporting of other post employment benefits (OPEBs) expenditures/expense and certain other related amounts in their financial reports. Historical claims information provided through the Medstat System will be vital to the state and its consulting actuary in projecting and accounting of post employment benefits. Loss of the system could impact the state's ability to accurately and timely obtain this information.

3) **Name and address of contractor's principal owner(s);**

The Medstat Group
777 East Eisenhower Parkway
Ann Arbor, Michigan 48108

4) **Description of procuring agency efforts to identify reasonable, competitive, procurement alternatives (rather than to use non-competitive negotiation);**

Given the scope of services (as illustrated in Sections 1 and 2) that are provided to the state through the Medstat system and the continued emphasis on the effective management of the state sponsored self insured plans, the governing bodies of the state sponsored plans has determined it is in the best interest of the State to extend the existing contract for an additional three years through 2008. Non-competitive negotiation is requested for the following reasons:

- Loss of specific functions designed for the state that are pre scheduled throughout the year such as evaluation of risk-sharing arrangements between the state and plan administrators.
- Possible disruption of up to six months to a year in the access to a claims analysis system necessary in order to manage the state sponsored self-insured plans.
- Additional cost of moving 36 months of claims data (or approximately 9 years of historical data) from existing system.
- Conversion costs for the future transmission of quarterly claims data.
- Possible loss of analytical capability available through the current database that allows the state to break down data in unique ways. Having continued access to these fields would enable the Division to continue its current reporting needs that the Insurance Committees and other state agencies have come to rely on.
- Inability to obtain accurate and timely health plan cost and utilization data necessary to meet upcoming GASBE requirements for accounting and reporting of post employment benefits (OPEBs).

5) **Justification of why the state should approve a Non-Competitive amendment.**

Based on the following summary of the reasons identified in question 1,2 and 4 the State Group Insurance Program feels it is necessary to extend the contract with the Medstat Group for an additional three-year term (January 1, 2006 through December 31, 2008):

- Given the volatility of health care costs, it is necessary to maintain continuity and consistency in the utilization of a claims analysis system so that timely and accurate information on plan cost and use is available for the management and administration of the state sponsored self-insured plans.
- Additional cost for converting 36 months of claims data
- Possible loss of specific functions described in Section 2.
- The costs of moving the State's current 36 months of data (or approximate 9 years of historical data) from the existing system.
- The time and cost of retraining.
- Impact on GASBE requirements regarding post employment benefits.

Your approval of this request, by your signature on the following page, would be appreciated. Please call me with any questions or concerns.

Respectfully,

Richard Chapman
Director, Insurance Administration

CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
317.04-003	FA5114095
State Agency	**State Agency Division**
F&A	Insurance Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
The MEDSTAT Group, Inc.	☐ C- or ☒ V- 06-1467923

Service Description

Storage of healthcare data, for research and insurance plan management purposes.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
1-1-95	12-31-08		

Mark, if Statement is TRUE

☒ Contractor is on STARS as required

☒ Contractor's Form W-9 is on file in Accounts as required

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
317.04	993	083	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
1995-2005			3,350,000		3,350,000
2006			1,050,000		1,050,000
2007			400,000		400,000
2008			100,000		100,000
2009			100,000		100,000
TOTAL:			5,000,000		5,000,000

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
1995-2005	3,350,000	
2006	50,000	1,000,000
2007		400,000
2008		100,000
2009		100,000
TOTAL:	3,400,000	1,600,000
End Date:	12-31-05	12-31-08

State Agency Fiscal Contact & Telephone #

Maureen Abbey
20th Floor, Snodgrass TN Tower
Nashville, TN 37243
741-0300

State Agency Budget Officer Approval

Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership

☐ African American ☐ Disabled ☐ Hispanic ☐ Small Business ☒ NOT minority/disadvantaged
☐ Asian ☐ Female ☐ Native American ☐ OTHER minority/disadvantaged—

Contractor Selection Method

☒ Original: RFP ☐ Competitive Negotiation ☐ Alternative Competitive Method
☒ This amdt: Non-Competitive Negotiation ☐ Government ☐ Other

Procurement Process Summary

Please see attached documentation, detailing justification.

AMENDMENT NUMBER SIX (6) TO CONTRACT FA5114095 BETWEEN THE STATE OF TENNESSEE, STATE INSURANCE COMMITTEE, LOCAL EDUCATION INSURANCE COMMITTEE, LOCAL GOVERNMENT INSURANCE COMMITTEE AND THE MEDSTAT GROUP, INC.

This contract, by and between the State of Tennessee, the State Insurance Committee, Local Education Insurance Committee, and Local Government Insurance Committee, hereinafter referred to as the State, and The MedStat Group, Inc., hereinafter referred to as the Contractor, is hereby amended as follows:

1. Insert the following to Section B., Scope of Services, as the fourth paragraph, and prior to the paragraph beginning "More specifically, ...":

   For the contract year beginning January 1, 2006, the Contractor shall:
   - **initiate the activities necessary to add MEDSTAT's Episode Grouper to its Advantage Suite database system;**
   - **enhance the database to include "Copay" and "Coinsurance" fields, to be populated separately, both retroactively and prospectively; and**
   - **implementation of up to one (1) new data source (carrier) per year.**

2. Delete Section B.1.b. in its entirety and insert the following in its place:

   B.1.b Data format conversions, for the periods indicated below, and with the designated components:

Contract Period	Vendor(s)	Required Components
January 1, 1995 through December 31, 1996	Blue Cross Blue Shield of Tennessee	data format conversion for the Plan Administrator in one format
January 1, 1997 through December 31, 1999	Blue Cross Blue Shield of Tennessee	medical and prescription drug claims in a single, consistent format specified by the Contractor
January 1, 1997 through December 31, 1999	HealthSource	medical and prescription drug claims and encounter records in a single, consistent format specified by the Contractor
Periods beginning on or after January 1, 2000	Blue Cross Blue Shield of Tennessee	medical and prescription drug claims in a single, consistent format specified by the Contractor
Periods beginning on or after January 1, 2000	John Deere Health Care, Inc.	medical and prescription drug claims and encounter records in a single, consistent format specified by the Contractor
Periods beginning on or after January 1, 2000	United Behavioral Health, Inc.	medical and prescription drug claims in a single, consistent format specified by the Contractor
Periods beginning on or after January 1, 2000 through December 31, 2000	United Healthcare of Tennessee	medical and prescription drug claims in a single, consistent format specified by the Contractor
Periods beginning on or after January 1, 2001	Aetna/Prudential	medical and prescription drug claims in a single, consistent format specified by the Contractor
January 1, 2003 through December 31, 2005	Blue Cross Blue Shield of Tennessee, Aetna, John Deere, Magellan Behavioral Health	Eligibility data feed: State of Tennessee; Medical Claims Data feeds: BCBST, Aetna, John Deere, UBH; Pharmaceutical Data feeds: BCBST, Aetna, John Deere
Periods beginning on or after January 1, 2006	Blue Cross Blue Shield of Tennessee, CIGNA, John Deere, Magellan Behavioral Health	Eligibility data feed: State of Tennessee; Medical Claims Data feeds from BCBST, Aetna, John Deere Health, CIGNA, and Magellan; Pharmaceutical Data feeds from BCBST, Aetna, John Deere Health, and CIGNA.

3. Delete Section C.4.a. in its entirety and insert the following in its place:

C.4.a. Monthly payments shall be made to the Contractor for the basic services described under Section B., SCOPE OF SERVICES. The fixed fees for each contract year (to be paid at the rate of one twelfth of the total) are as follows:

Calendar Year	Total fixed fee for basic services
1995	$190,000
1996	$199,500
1997	$226,931
1998	$287,240
1999	$262,080
2000	$262,080
2001	$273,442
2002	$281,645
2003	$290,094 plus a migration to Advantage Suite cost of $50,000 (total fixed fee for 2003 = $340,094)
2004	$298,796
2005	$307,760
2006	$312,376
2007	$317,062
2008	$321,818

Beginning with contract year 2003, if any of the eight required data feeds (see Section B.1.b) are eliminated, there will be a corresponding decrease of Five Thousand Dollars ($5000) per eliminated data feed, for each of the remaining years of the contract. If any such elimination should occur at any point other than on a calendar year basis, this $5000 fee decrease will be prorated, as mutually agreed by both parties.

4. Delete Section C.4.b. in its entirety and insert the following in its place:

C.4.b. For each contract year (Column A below), fixed fees cover up to the number of employees (Column B) whose medical claims are administered by the Plan Administrator(s). If the average number of contracts exceeds the total in Column C, the State shall pay to the Contractor the amount in Column D, for all contracts in excess of the number in Column C, at the rate indicated.

A. Contract Year	B. Fees cover up to___:	C. If contracts exceed...	D. ...the State will pay to the Contractor...
1/1/1995 –12/31/1997	110,000	110,000	$0.43 per contract per quarter
1/1/1998 –12/31/1999	112,000	112,000	$2.19 per contract per year
1/1/2000 –12/31/2005	150,000	150,000	$2.43 per contract per year
1/1/2006 – 12/31/2008	150,000	150,000	$2.43 per contract per year

5. Delete Section E. in its entirety and insert the following in its place:

E. Contract Term: This Contract shall be effective for a period commencing on January 1, 1995 and ending on December 31, 2008. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

The other terms and conditions of this contract not amended hereby shall remain in full force and effect.

IN WITNESS WHEREOF:
THE MEDSTAT GROUP, INC.:

Carol Deiphuis, Executive Vice President **Date**

STATE OF TENNESSEE
STATE INSURANCE COMMITTEE
LOCAL EDUCATION INSURANCE COMMITTEE
LOCAL GOVERNMENT INSURANCE COMMITTEE:

M. D. Goetz, Jr., Chairman **Date**

APPROVED:
DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner **Date**

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury **Date**

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
INSURANCE ADMINISTRATION
312 Eighth Avenue North
Suite 1300 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-3590 or (800) 253-9981
FAX (615) 741-8196

Dave Goetz
COMMISSIONER

Richard Chapman
DIRECTOR

August 5, 2005

MEMORANDUM

TO: Leni S. Chick, Contract Analyst
Fiscal Review Committee

FROM: Richard Chapman

SUBJECT: Contract Exception Material

Enclosed, pursuant to our conversation earlier this week, is material provided to the members of the State, Local Education and Local Government Insurance Committees on May 13, 2005. The subject is Contract Extensions for contracts that are under the jurisdiction of the three Insurance Committees. A copy of the minutes of the meeting is also enclosed. Because these two items represent extension of contracts beyond a five year duration for business considerations, I believe they are subject to review by the Fiscal Review Committee.

The first contract for consideration is a contract with BlueCross BlueShield of Tennessee for administration of the retiree's Medicare Supplement coverage. There are approximately 22,000 retirees and eligible dependents covered by one of the three options for these retirees who are Medicare eligible by virtue of age. This contract has been in effect since January 1998 when it was secured through a competitive procurement. At that time, the coverage was fully insured and the contract included a return of excess premium provision. The contract remained fully insured for 1998, 1999 and 2000 and was converted to a self-insured product effective January 2001 and the contract for administrative services remained in effect for two years (2001 and 2002). The contract was extended for two additional years (2003 and 2004) and then effective January 2005 the contract was extended for one year. Each of these actions was approved by the Commissioner of Finance and Administration and the Comptroller under the contract rules that existed at the time these actions were taken. They were initiated by the State Insurance Committee which has jurisdiction in this matter.

Beginning January 2006, a pharmacy benefit will be available through Medicare (the new Part D) and a number of restrictions will be placed upon Medicare Supplement plans. These actions are a result of the federal Medicare Modernization Act. In reviewing this matter, the State Insurance Committee

considered a recommendation from the Division of Insurance Administration that the State Medicare Supplement options be consolidated into a single offering, that the state support continue in the service-based, fixed amount legislative framework and that retirees be encouraged to participate in the new Part D pharmacy benefit. Obviously, there are a number of logistical concerns that relate to a significant transition in the benefit structure available to retired teachers and state employees through the Medicare Supplement Plan. It has been the determination of the State Insurance Committee that extending this contract through the end of calendar year 2006 will be beneficial to retirees in that the consistency of the administrative framework will not further complicate the situation of a change in benefit structure. The Insurance Committee adopted that posture on May 13, 2005 and the terms of the contract extension have not been negotiated with the State of Tennessee.

The second matter relates to the provision of claims analysis, decision support system activities through a contract with the Medstat Group. This contract has been in effect since 1994 and has been extended by the Insurance Committees on a number of occasions. This contract is the source of analytical tools which are used to evaluate claims payment information that is maintained in a data warehouse. Claims payment information originates with the plan administrators and eligibility information originates with the State of Tennessee. As you may know, the State sponsors three different healthcare offerings that are available in various geographic portions of the state. The Division of Insurance Administration employs this management tool to analyze utilization and cost information that is provided by the plan administrators that is unique to each the individual healthcare offerings available to participants in the state sponsored plans. The Division has two individuals who have been trained by Medstat to utilize the software and a number of other individuals who access standardized reports online. The Division relies on this management tool to identify trends in healthcare costs, assist in the preparation of data that is made available to plan members on our website, prepare analytical reports for public policymakers (including Members of the General Assembly) and assist in the overall management of health insurance benefits for approximately 134,000 public sector employees in Tennessee. The principle reasons for extending this contract are continuity in the provision of management information to plan management, the ability to maintain access to historical data through a consistent analytical tool, avoiding the cost of transferring the existing database and providing for conversion of reporting formats by contractors. There are two additional considerations that are important in the review of this three year extension request. First, the Division of Accounts in currently involved in a project to identify other post employment benefits costs that are required under GASB Rules 43 and 45. The data for conducting these assessments is found in the Medstat decision support system and there is likely to be a continuing obligation, extending well through 2006, for access to data that is separable by employer (this applies to the Local Education and Local Government Plans). The second issue pertains a recent contract award by the Bureau of TennCare to Medstat to supply similar decision support system tools to that Bureau. The contract is in effect and the capability is being established. Having the ability to use essentially the same software tools to analyze utilization and cost information for two distinct, but statistically large scale, populations in Tennessee would be advantageous.

The terms for extending this contract have been discussed with the contractor and Medstat is agreeable to a one and one-half percent increase, on an annual basis, for each of the three years beginning January 2006. As part of our discussions, Medstat has agreed to enhance the existing service by providing an episode grouper which enables the analytical software to assemble all claims associated with treatment of a specific medical event (an episode) and permit the analysis of that information. The Division believes that is a significant improvement in the existing tool and based upon the initial price attached that offering represents a value greater than the proposed increase in the administrative fees. The proposed contract amount for 2006 is $312,000 which would grow to approximately $322,000 for 2007.

As indicated previously, I have attached the material that was provided to the Insurance Committee relative to this matter and a copy of the draft minutes of the May 13, 2005 session of those governing bodies. Should you have any questions concerning this matter, please feel free to contact me at your convenience. If you believe it is appropriate, please let me know if I should attend the August 10, 2005 work session.

RLC/s

(DRAFT COPY)

Minutes
State, Local Education and Local Government Insurance Committees
May 13, 2005

The State, Local Education and Local Government Insurance Committees met on May 13, 2005 at 9:30 a.m. in the 27th floor Conference Room, William R. Snodgrass Tennessee Tower, Nashville, Tennessee. Dale Sims, State Treasurer, chaired the meeting in the absence of Commissioner Goetz. Attending members were:

State Insurance Committee

*John Morgan, Comptroller of the Treasury
*Dale Sims, State Treasurer
Larry Knight, representing Commissioner Flowers, Department of Commerce and Insurance
Nat Johnson, representing Commissioner Camp,
Linda McCarty, representing TN State Employees Association
Tom Spillman, Employee Representative
Debbie Johnson, representing Higher Education
Jeannie Bellephant, Employee Representative

Local Education Insurance Committee

*Ex-Officio Members
Clark Justis, Teacher Representative
Donna Barber, Teacher Representative
Josephine King, Teacher Representative
Jim Jones, Department of Education
Phillip White, TN School Board Assn.

Local Government Insurance Committee

*Ex-Officio Members
Bob Wormsley, representing TN County Services Association
Randy Williams, TN Municipal League

Division of Insurance Administration Staff

Richard Chapman	Sherry Buchanan	Gail Cantrell
John Anderson	Paul Hauser	Teresa Liles
Keith Athow	Debbie Smith	Bob Smith

The meeting was called to order at 9:40 a.m.

The first item on the agenda was Approval of Minutes. Mr. Johnson made a motion that the minutes of the September 8, 2004 meeting of the State, Local Education and Local Government Insurance Committees be approved as presented. Mr. Williams seconded the motion which passed unanimously. Next, Mr. Sims made a motion that the minutes of the November 8, 2004 meeting of the State Insurance Committee be approved. Mr. Knight seconded the motion which passed unanimously.

The next item on the agenda was Medicare Pharmacy Part D Presentation. Mr. Jim McCready and Mr. Michael Jacobs with Mellon Human Resources presented a slide presentation regarding the provisions of the Medicare Modernization Act (MMA) which included the addition of Pharmacy Benefits (Part D) to Medicare coverage effective January 1, 2006. (A copy of the slide presentation is incorporated as part of the minutes). Mr. McCready summarized the key provisions of the Act and presented an overview of the current state sponsored Medicare Supplement plan offerings. With the changes to Medicare, Mr. McCready indicated that the State would be required to make changes to state sponsored offerings; some of the options involved:

- Modifications to the current benefits and qualification for the 28% federal subsidy
- Integration with Medicare Part D and payment of Part D premium by participants
- Offering Medicare Advantage Plans

- Elimination of prescription drug coverage
- A combination of the above items.

Members of the Insurance Committees reviewed the implementation issues and discussed the timeframes involved to provide adequate communications to the retirees. Of particular concern was the fact that retirees be notified of the open enrollment period for Medicare Part D and the penalty assessed if enrollment was delayed. Additionally, members expressed concern of the impact of the changes to individuals enrolled in Plan 3 as that option experiences adverse risk due to self-selection and has above average prescription drug expenses.

Members of the Committees were asked to provide staff with any recommendations and that action would be considered at a June meeting of the State Insurance Committee, with whom the jurisdiction for the Medicare Supplement Plans rests.

The next item on the agenda was a review of the guidelines concerning Continuation of Insurance Coverage by Survivors of Employees. Mr. Richard Chapman, Director, explained that this item dealt with the individuals maintaining family coverage by one of the three Plans at the time of their death and the ability of their dependents to continue coverage. This matter was presented to the Committees as the policy making body, as the Division of Insurance Administration and the Tennessee Consolidated Retirement System were attempting to clarify the manner and criteria under which continuation of coverage by survivors was to be granted. Based upon a review of the minutes of meetings of the Insurance Committees, no specific record of action taken to establish a policy on continuation of insurance coverage for surviving dependent of an employee who dies in service could be found. Mr. Chapman reviewed the criteria for continuation of coverage for each of the three state sponsored plans and noted specific additional criteria for individuals participating in the optional retirement plan, certain public safety personnel participating in the Local Government Plan and criteria for the exchange of credit between plans. Mr. Chapman stated the retirement program provides for service retirement, disability retirement and for the provision of a death benefit to the survivors of employees who have 10 years of service who die prior to qualification for a service retirement or a disability requirement. The Retirement Division holds the position that if the survivors qualify to draw an in-service death benefit and the employee met the normal insurance requirements, they should be authorized to continue insurance coverage if they are already in the Plan. The position of the Division of Insurance Administration is that individuals who qualify for an ordinary death benefit are only entitled to continuation of coverage if the employee, at the time of death, was eligible to retire and qualified for a continuation of insurance coverage based upon the criteria established by each Plan. At issue are individuals who have at least 10 years of service but whose death occurs prior to attainment of age 55 or 25 years of service.

Mr. Ed Hennessee, Director, Tennessee Consolidated Retirement System, addressed the Committees and stated that in 1980 the state's retirement law was amended to authorize a death benefit to a surviving spouse if the employee had complete ten years of service. Prior to that time, monthly benefits were only offered if the deceased employee was eligible to retire prior to death; the insurance eligibility standards were applied to surviving beneficiaries and insurance continuation was permitted if the normal conditions were met as if the deceased employee were retiring. Mr. Hennessee advised the Committees that the Internal Revenue Service recognizes three triggers for retirement benefits; disability, termination of employment and death. For purpose of disability, there is a five year requirement. It is the position of the Tennessee Consolidated Retirement System that the surviving dependents already covered by the state sponsored insurance coverage should be allowed to continue coverage in the event of an in service death and Mr. Hennessee noted that this is the current practice of TCRS. Mr. Hennessee noted that the eligibility criteria relative to in service death should be consistent among all of the state sponsored plans. The current practice of TCRS is to allow continuation of insurance coverage at the time of in service death and both entities noted that due to the number of dependent potentially affect, financial considerations should not be a factor in the discussions as the cost of providing access to coverage is including in each plan's current cost.

Mr. Morgan made a motion to continue the practice of insurance continuation for dependents covered under the state sponsored plans if an employee dies while in service. Ms. McCarty seconded the motion. It was noted that the specific language to be used should be developed by the Division of Insurance Administration and TCRS jointly. The motion passed unanimously.

The next item on the agenda was Contract Extensions. Mr. Sims called upon Mr. John Anderson, Assistant Director, Division of Insurance Administration, to address the Committee on this matter. The first contract under review was with BlueCross BlueShield of Tennessee for the statewide PPO option. Mr. Anderson stated that the expiration of present contract with BlueCross BlueShield of Tennessee for provision of administrative services to the statewide PPO was December 31, 2005 and that the contract provides for a one-year extension through 2006. Under the proposed contract extension, the administrative fees would remain the same and the trend factor applicable to the 2006 risk-sharing arrangement would equal 7.5 percent. One additional consideration was a request from BlueCross that if member population declined by 20% or more, the State and BlueCross would review the administrative fees to determine if they should be increased at a rate not to exceed 3.5%. Mr. Morgan made a motion that the contract with BlueCross BlueShield of Tennessee for administration of the statewide PPO contract be extended for one year, until December 31, 2006. Mr. Johnson seconded the motion which passed unanimously.

The next contract extension dealt with benefit consultant services provided by Mellon Consultants, Inc. Mr. Anderson explained that the current term of the contract would expire on December 31, 2005 and that the contract provisions allow for two, one-year extensions. It was noted that the hourly fees for consulting services would remain in effect and all other terms and conditions of the contract would remain the same. Mr. Morgan made a motion that the Insurance Committees extend the current contract with Mellon Consultants for benefit consultant services for one year, through December 31, 2006. Mr. Johnson seconded the motion which passed unanimously.

Next, Mr. Anderson discussed the contract with Medstat for Claims Analysis Decision Support System which will expire on December 31, 2005. The Medstat system provides web access to three years of paid and incurred claims data and provides both standard and individually formatted reporting for use in the analysis. Mr. Anderson explained that the current contract contains no provisions for an extension and that an exception to the competitive procurement would be required. The request is for a three-year extension beginning January 1, 2006 and will require approval by the Fiscal Review Committee. The terms of the proposed extension were reviewed; those included an increase in the administrative fees and several enhancements to the databases including the "Episode Grouper" feature which provided per episode of care cost. Mr. Anderson stated that loss of access to claims information data could cause of disruption of planning and analytical functions and production of reports and outlined the staff's rationale for requesting a three year extension. In response to questions from the Committee, Mr. Anderson noted that the current contract had been in effect since the initial procurement in 1995. Mr. Spillman asked if the State maintained a separate copy of the claims data and Mr. Anderson responded that the individual plan administrators provide information directly to Medstat for use in the decision support system. The Committee expressed concern about the ownership of the data supplied to Medstat and if the contract had specific reference to Medstat's obligation to the return the data if the contract were terminated for any reason. The staff indicated that the contract did contain the standard termination for convenience clause and they would review the contract for provisions on return of data. Ms. Johnson asked if the staff felt that the fee was justifiable since no procurement since the original request had been sought. Mr. Anderson responded that the staff felt that the fee was reasonable with the addition of the enhanced databases services. Mr. Morgan made a motion that the Committee extend the current contract with Medstat for claims analysis decision support system and that they seek approval from the Fiscal Review Committee to proceed. Mr. Johnson seconded the motion which passed unanimously.

The next contract extension for review dealt with the provision of administrative services to the Medicare Supplement Plan currently with BlueCross BlueShield of Tennessee. The current contract is scheduled to expire on December 31, 2005 and there are no provisions for an extension. Mr. Anderson noted that given the uncertainties and timeframes involved in the implementation of the new Medicare Part D pharmacy program, the state would like to negotiate a one year extension to the current contract to provide a qualified Medicare Supplement plan for Parts A and B of Medicare. The terms of the contract have not been reviewed and the matter would require review and approval by the Fiscal Review Committee. Mr. Johnson made a motion that the State Insurance Committee negotiate a one-year extension to the current contract with BlueCross BlueShield of Tennessee subject to review and approval by the Fiscal Review Committee. Mr. Morgan seconded the motion which was approved unanimously.

The next item on the agenda was Contract Award for the Optional Universal Life Insurance Coverage. Mr. Paul Hauser advised the Committee that the Division of Insurance Administration had issued a Request For Proposal (RFP) on February 18, 2005 to 35 recipients for the provision of Optional Universal Life Insurance for state employees with an intended term of September 1, 2005 through June 30, 2008 with options to extend for two additional one year periods. The Division held a pre-proposal conference on March 2, 2005 which was attended by representatives of eight companies and responded to 94 vendor comments, questions and requests for clarification. Mr. Hauser reported that only one proposal was received from UnumProvident and that the proposal was evaluated for and met all Mandatory Proposer Qualifications. Because UnumProvident submitted the only proposal and it met all of the RFP requirements, a full evaluation was not required. Mr. Hauser indicated that that at least three members of the Evaluation Team had completed a thorough review of the proposal to assure that the proposer understood the requirements in the contract. Based upon this information, the Evaluation Team recommended that the State Insurance Committee enter into an agreement with UnumProvident for the delivery of the State's Optional Universal Life Insurance program. In response to questions from the Committee, Mr. Hauser advised that approximately 8,000 individuals were currently enrolled in the Optional Universal Life coverage.

Mr. Spillman made a motion that the State Insurance Committee accept the Proposal Evaluation Team's recommendation and enter into an agreement with UnumProvident for the delivery of the State's Optional Universal Life Insurance program. Mr. Morgan seconded the motion which passed unanimously.

Next, Mr. Hauser reported that the Division of Insurance Administration had issued an RFP on February 18, 2005 to 35 recipients for the provision of Optional Term Life Insurance for state employee with an intended term of September 1, 2005 through June 30, 2008 with options to extend for two additional one year periods. The Division held a pre-proposal conference on March 2, 2005 which was attended by representatives of eight companies and responded to 106 vendor comments, questions and requests for clarification. Mr. Hauser advised that proposals were received from Minnesota Life, Prudential, UnumProvident and USAbleLife. Mr. Hauser briefly outlined the proposal evaluation criteria and indicated that all proposals were evaluated for and met the Mandatory Proposer Qualifications. The Committee members were provided with the scores for the technical responses to the proposal which contained information relative to the General Qualifications and Experience and Technical Approach. Mr. Hauser stated that in the cost proposal, proposers were asked to indicate their proposed monthly age bracketed premium rates and administrative charges for the initial three year contact period; a summary of that information was provided. The Evaluation Team recommended that two proposals – Minnesota Life and Prudential – be disqualified as these proposers inserted conditional terms in their Cost Proposals. In the case of Minnesota Life, the proposal indicated that the quote provided was valid for 90 days and reserved the authority to review and modify monthly premium rates as necessary if actual enrollment changed by 10 percent or plan design differed materially; the State required a 120 day quote validity statement and no qualifications. The Prudential proposal contained a statement which indicated that should enrollment or volume change of more than 10 percent during the initial rate guaranteed period from those stated in the proposal, the company reserved the authority to take immediate action, including but not limited to revising monthly premium rates or

terminating coverage. Mr. Hauser noted that a proposer may not reserve the right to revise the monthly premium rates or to terminate the contract without meeting the notice of termination requirements contained in the pro forma contract.

Mr. Hauser distributed corrected vendor scoring sheets and advised that the Evaluation Team recommended that the Committee enter into an agreement with UnumProvident Life Insurance for delivery of the State's Optional Term Life Insurance program. It was noted that the premiums stated in cost proposal would create a savings of $95,000 per month to the program participants when compared to current rates, Mr. Morgan asked if any discussion was held during the pre-proposal conference of items that would cause a proposal to be disqualified. Staff responded that they were unsure whether that matter was discussed at the conference; however, the RFP was specific that any qualifying statement or specific proposer qualifications would subject the proposal to disqualification. or to being declared non-responsive. Mr. Chapman noted that the RFP contained five years of history data regarding the volume of coverage and enrollment numbers. Members of the Committee asked if the state sought clarification from the proposers on the disqualification items in the Cost Proposal. Mr. Chapman responded that under the provisions established for cost proposal review, the Division as the issuing agency and the Evaluation Team is not permitted to discuss deviations with the proposers. The Committee members reviewed the cost proposal information submitted in the proposals and noted that the cost to provide this coverage to employees could be significantly lowered if all proposals had been evaluated rather than two being recommended for disqualification. Mr. Morgan recommended that the staff seek approval to contact the two proposers who had submitted cost proposals with qualifying language to determine if they would remove the qualifying language. Based upon Mr. Morgan's recommendation, Mr. Spillman made a motion that the staff evaluate the four proposals received without consideration to the qualifying language related to the cost proposals and provide that information to the Committee at a subsequent meeting to take action on the procurement. Ms. McCarty seconded the motion which passed unanimously.

The next item on the agenda was RFP Status Report. Mr. Hauser advised the Committee that the RFP for health maintenance organization services in Memphis and Nashville had been issued on April 21, 2005 and that proposals were due in mid-June. The RFP for the Point of Service healthcare option for middle, east and west Tennessee was issued on May 3, 2005 and proposals are due in mid-June. The Committee was advised the RFP for optional prepaid dental services was in the developmental stage and would be issued in the next month.

At the request of the Committee, agenda item 7 was deferred to the end of the meeting.

The next item for the Committee's review involved Eligibility Issues related to the state sponsored plans. The first issue dealt with the expansion of employee eligibility criteria to include transfer of existing coverage between the State, Local Education and Local Government Plan. Mr. Chapman noted that under the current criteria, the Local Education and Local Government Plan permit a husband and wife that are both employed by two separate agencies participating in the same plan to transfer their existing coverage on January 1st of each when it is to their advantage to do so. The proposal before the Committee would permit a change in the eligibility criteria for employees that are eligible for coverage under more than one state sponsored plan to permit a transfer between all three state sponsored plans on January 1st of each year. Mr. Justis made a motion to approve the staff recommendation. Mr. Morgan seconded the motion which passed unanimously.

Next, the Local Government Committee reviewed a staff recommendation to audit the continuing eligibility for participation by quasi-governmental organizations participating in the Plan. Mr. Chapman explained that under the current participation guidelines, the Local Government Plan permits participation of quasi-governmental organizations that qualify by meeting one of the following criteria:

1. not-for-profit agency receiving state funding or grant and sponsored by an agency of state government;
2. members of the Tennessee Municipal League; or
3. any entity that participates or is eligible to participate in the Tennessee Consolidated Retirement System.

The staff recommendation included a termination date of December 31, 2005 for those quasi-governmental agencies that no longer met the criteria. Mr. Chapman advised that 146 quasi-governmental organizations were enrolled in the Local Government Plan. The Committee granted authority to the staff to conduct the audit and requested that the audit results be provided to the Committee prior to disenrollment of any agencies from the Local Government Plan.

The next item for the Committee's consideration dealt with Eligibility Requirements for employers of certain sizes applying for participation in the Local Government Plan. Mr. Chapman noted that the Local Government Plan had maintained a tiered premium structure since its inception in 1989. Initially, the Plan designated six tiers to the premium structure; currently there are three tiers with the difference in monthly premiums between the tiers being approximately 9%. The assignment to a premium tier is predicated upon a statistical analysis and factor weighting assignment of employees from an entity joining the Local Government Plan based on their distribution by gender and age; approximately 90% of employers participating in the Plan are in tier one. Retirees, if participating in the plan, are rated and assigned different health insurance risk factors than employees of the same age and gender. The Committee was advised that one of the factors that contributed to adverse financial results that occurred during the three years ending with 2003 was the utilization trends by at least one large employer that represented more than 10% of the plan membership. Based upon this factor, the Local Government Insurance Plan had requested staff to propose ways to insulate, or at least reduce the possibility of this type of occurrence in the future.

Mr. Chapman presented a staff recommendation that would establish a second level of review for employees that represent more than 1% of Plan membership. The recommendation would require the employer to provide two calendar years (January – December) of monthly claims payment information for all options offered by the employer and the number of covered lives for each month. This information would be used to calculate a per capita benefit payment amount which would be compared to the per capita expenses for the Local Government Plan. Employers who had per capita benefit expenses less than 100% of the Local Government Plan expenses, would be assigned tier one premiums. For scores of 100%-105%, employers would be assigned to tier two; scores greater than 105%, would be assigned to tier three. In the event that the demographic/gender tier assignment is different than the substitute calculation, the calculation that determines the highest tier level would prevail. Mr. Chapman further explained that employers that represent more than 3% of the plan membership, the staff recommendation would require that the assessment also involve the evaluation of the plan offerings by the employer compared to the benefit structure of the Local Government Plan. Mr. Wormsley made a motion that the Local Government Insurance Committee adopt the staff recommendation as presented. Mr. Williams seconded the motion which passed unanimously.

The next eligibility issue dealt with expansion of eligibility criteria for interim teachers. Mr. Chapman explained that newly hired teachers, including interim teachers, are permitted to elect coverage within 31 days of their initial employment. In many cases the interim teacher do not enroll when first eligible because they consider their teaching position to be a temporary employment. Mr. Chapman presented a staff recommendation that the Local Education Insurance Committee approve the expansion of the eligibility criteria to include a second period of eligibility for interim teachers who do not elect coverage when first eligible but subsequently accept a permanent teaching position at the same school system without a break in employment. Mr. Justis made a motion to accept the staff recommendation as presented. Mr. Morgan seconded the motion which passed unanimously.

The next item for the Committee's review was the criteria for continuation of medical coverage as retirees for school board members and utility district commissioners. Mr. Chapman advised the Committee that school board members of participating local education agencies and utility district commissioners are eligible for coverage as long as they serve in these positions with participating agencies due to recent changes in state law. The issue for consideration dealt with the eligibility for either class of individual to continue coverage upon retirement. The legislation which permitted this class of employees to be eligible for coverage was not specific as it related to eligibility for coverage upon retirement. Mr. Chapman noted that the Local Education and Local Government Insurance Committees could elect to extend the retirees continuation provision to these individuals and recommended the following criteria for consideration:

- 20 years of services as a member of the same school board or as a commissioner with the same utility district and one year in the insurance plan and attainment of age 55

- 30 years of service as a member of the same school board or as a commissioner with the same utility district and one year in the insurance plan.

In response to questions from the Committee, Mr. Chapman reviewed the retiree eligibility requirements for continuation of coverage for the three state sponsored plans. The Committee was advised that the participation requirements are waived for agencies who have not been in the Plan for the required length of time and that agencies are required to withdraw their retirees and COBRA participants from the Plan in the event that the agency terminations participation. Mr. Jones made a motion that the Local Education and Local Government Insurance Committee extend continuation of insurance coverage as retirees to school board members and utility district commissioners and adopt the staff recommendation for the criteria to be utilized. Mr. Wormsley seconded the motion which passed without objection.

The next item on the agenda was a Review of the Results of February 2005 Evaluation of Equal or Superior Schools Systems. Mr. Chapman advised the Committee that the legislation which authorized the establishment of the Local Education Plan provided for local education agencies to maintain coverage for employees through a stand alone plan if they operated such a plan. The legislation further stated that the Committee shall periodically review local education agency plans to ensure that such plans maintain benefits that are equal or superior to the basic plan and that failure to maintain these benefits could subject the local plan to discontinuation of financial support from the state government. Mr. Chapman noted that these payments are currently made under the Basic Education Plan (BEP) funding mechanism. The Committee was informed that the State, at the request of the Tennessee Education Association, had conducted a review of the local education agencies that have an equal or superior designation in February of 2005. Mr. Chapman noted that the scoring methodology for evaluation of the plans included plan design features, i.e., deductibles and co-payments, maximum benefits and out of pocket allowances, prescription drug benefits, etc. and included the evaluation of different types of healthcare offerings (PPO, POS and HMO). The Committee was advised that the methodology utilized by Mellon was similar to that used by the prior benefits consultant and that information had been shared with the Committee previously. The methodology assessed a score of 105% of the value of the state sponsored plan as superior, scores of 95% to 105% were considered equal and a score of less than 95% was considered not equal. The results of the evaluation indicated that a number of healthcare options offered by 10 of the stand-alone districts did not meet the equal or superior designation. Mr. Chapman outlined options that the Committee could take relative to these results which included notification to the local education agency of the deficiency and withholding financial support or modification of the criteria for equal or superior designation. Additionally, the Committee reviewed several secondary considerations such as collectively bargained arrangement between school systems and employees, local education agencies that offer more than one healthcare option that employees are allowed to choose and instances where the county local government employees and local education employees are enrolled in a single plan, that might have an impact on the option to pursue instances where LEAs are offering non-qualified plans.

Robin Donsbach of Mellon Consulting answered several questions from members of the Committee and noted that the software used to access the equal or superior designations had been updated in 2004. Ms. Donsbach explained that the basic benefits including deductible, co-insurance, co-pay and prescription drug coverage are entered into the software and a value is assigned for each. Ms. Donsbach indicated that representatives of Mellon could assist with the local education agencies in determining which changes in benefit would change the value of their designation. It was also noted that the review for equal or superior designation was not based on premium sharing between the employee and employer. Several members of the Committee indicated they were not in favor of changing the criteria to a lower percentage to maintain the equal or superior designation. Following a lengthy discussion, Mr. Morgan recommended notifying the affected agencies that the initial evaluation indicated that they no longer meet the equal or superior designation and that they will be given until July 1, 2006 to correct the deficiencies. Mr. Chapman reiterated the ability of Mellon to work with the local education agencies to make recommendations on benefit changes that would allow them to meet the percentage standards for an equal or superior designation. Members of the Local Education Committee requested that the all school systems be sent a notice that the equal or superior designations have been under review and that local education agencies are required to maintain such a designation if they choose to participate in a stand alone plan rather than enroll in the Local Education Plan. It was requested that the notifications be sent to the Tennessee Education Association as well.

Mr. Justis made a motion that local education agencies that were deficient for an equal or superior designation be contacted and advised that they have until July 1, 2005 to correct deficiencies. Mr. Sims seconded the motion which passed unanimously.

Mr. Chapman recognized Mr. Jack Lay who had been a long time partner from Blue Cross Blue Shield and had worked closely with the Division of Insurance Administration.

There being no further business, the meeting was adjourned.

Respectfully submitted,

Richard L. Chapman

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
INSURANCE ADMINISTRATION
312 Eighth Avenue North
Suite 1300 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-3590 or (800) 253-9981
FAX (615) 741-8196

Dave Goetz
COMMISSIONER

Richard Chapman
DIRECTOR

MEMORANDUM

TO: Members of the State, Local Education and Local Government Insurance Committees

FROM: Richard L. Chapman

DATE: May 13, 2005

SUBJECT: Contract Extensions

The purpose of this correspondence is to request Insurance Committee approval of the following contract extensions based on the terms negotiated by the Division. Except for the MedStat and Medicare Supplement contracts, each of the current contracts authorizes at least a one-year extension. The specific terms and conditions for each of the contract extensions as recommended by the Division are as follows:

1. **Statewide PPO option – BlueCross BlueShield of Tennessee:** The present term of the contract with BlueCross BlueShield of Tennessee for the provision of administrative services to the statewide PPO plan expires on December 31, 2005. The contract allows for a one-year extension through 2006. As of 2005, the PPO plan covered 107,293 lives or 41 percent of all lives covered by the state sponsored plans. Proposed terms for the extension of the PPO contract proposed for the year 2006 are as follows:

2006 BCBST PPO CONTRACT EXTENSION PROVISIONS

- Administrative fee for the State, Local Education and Local Government PPO Plans will remain at the present rate of $18.28 Per Member Per Month (PMPM).
- Under the 2006 risk-sharing arrangement, the trend factor will equal 7.5 percent. This represents the same 7.5 percent trend for the 2005 plan year.
- Blue Cross is also requesting that if for plan year 2006 the member population of the PPO declines by 20% or more, the State and Blue Cross will review the administrative fees to determine if they should be increased at a rate not to exceed 3.5%.
- All other terms and conditions of the contract will remain the same

2. **Benefit Consultant Services - Mellon Consultants, Inc (formerly Buck Consultants):** The present term of the contract with Mellon Consultants, Inc for the provision of benefits consulting services terminates on December 31, 2005. The contract allows for two, one-year extensions. Terms for the extension of the PPO contract proposed for the year 2006 are as follows:

2006 MELLON CONSULTANT EXTERNSION PROVISIONS

- Hourly fees will remain the same for the year 2006
  - Senior Consultant (Principal) - $400
  - Senior Consultant (Non-Principal) - $375
  - Consultant - $290.00
  - Analyst - $100
  - Admin/Clerical $75.00
  - Medical Professional - $300
- All other terms and conditions remain the same.

3. **Claims Analysis Decision Support System – MedStat Group (Exception Request):** The present contract with the MedStat Group for the provision of claims analysis and decision support services for all self-insured health plans sponsored by the state terminates on December 31, 2005. There are no provisions for an extension to the contract, consequently an exception to competitive procurement is requested. The request is for a three-year extension from January 1, 2006 through December 31, 2008. The MedStat system provides web access to three years of paid and incurred claims data. Standard reporting, as well as detail, individually formatted reporting, is available for use in the analysis. Because the loss of access to this claims information may cause a disruption to planned functions and production of specific reports an exception is being requested for the following reasons:
   - Loss of specific functions designed for the state that are pre scheduled throughout the year such as evaluation of risk-sharing arrangements between the state and plan administrators.
   - Possible disruption of up to six months to a year in the access to a claims analysis system necessary in order to manage the state sponsored self-insured plans.
   - Additional cost of moving 36 months of claims data (or approximately 9 years of historical data) from existing system.
   - Conversion costs for the future transmission of quarterly claims data.
   - Possible loss of custom fields in its database that allows the state to configure data in unique ways. Having continued access to these fields would enable the Division to continue its current reporting needs that the Insurance Committees and other state agencies have come to rely on.
   - Inability to obtain accurate and timely health plan cost and utilization data necessary to meet upcoming GASB 43 and 45 requirements for accounting and reporting of post employment benefits (OPEBs). Detailed reporting will be necessary in order to establish potential liability and to support an actuarial study required by the new accounting rule.
   - The cost of retraining Division staff in the use of another decision support system software.

2006 – 2008 MEDSTAT GROUP CONTRACT EXTENSION PROVISIONS

Fees:

- 1.5% increase per year (2005 amount is $307,760)
- 2006 - $312,376
- 2007 - $317,062
- 2008 - $321,818

Key Terms:

- License volume: 150,000 employees and retirees
- Data feeds:
  - Eligibility: 1 from the State of Tennessee (submitted monthly)
  - Medical Claims: 4 total from BCBST, Aetna, John Deere, and Magellan
  - Other: BCBST Rx, Aetna Rx, John Deere Rx
- Database: Contains 36 months of paid claims, updated quarterly
- Database enhancements:
  - "Copay" and "coinsurance" fields in the State of Tennessee database to be populated separately, both historically and going forward
  - Add Medstat's Episode Grouper feature providing cost per episode of care
  - Implementation of up to one (1) new data source (carrier) per year
- Advantage Suite (software name) user licenses: 3
- Medstat Connection Conference registrations: 2 per year
- Maintenance fees decrease by $5,000 annually with any reduction in feeds during term of contract
- Ongoing telephone product support and analyst support are included at no additional charge
- Training in Ann Arbor for one (1) person on State of Tennessee database
- Any additional consulting services or specific analytic deliverables will be based on hourly rates included in the present contract

This item will require review and approval by the Fiscal Review Committee.

4. **Medicare Supplement Plans – BlueCross Blueshield of Tennessee (Exception Request):** The present term of the contract with BlueCross BlueShield of Tennessee for the provision of administrative services to the three (3) Medicare Supplement plans expires on December 31, 2005. There are no provisions for an extension to the contract, so an exception to competitive procurement would be required. Given the uncertainties and the time frames involving the implementation of the new Medicare Part D pharmacy program, it would be advantageous for the state and it's retirees to be able to extend the contract with Blue Cross for a qualified Medicare Supplement plan providing supplemental coverage for Part A and B of Medicare.

   The Division is requesting approval from the State Insurance Committee to negotiate a one year extension to the existing contract accompanying a potential modification to the number of supplement plans offered.

   This item will require review and approval by the Fiscal Review Committee.

The Division of Insurance Administration requests approval of the Insurance Committees for the recommended actions to the contracts listed above.